# RELEASE FORM

I, ______________________________ give permission for my child's medical/audiological information to be shared with The Luke Lee Listening Language and Learning Lab at Marshall University for the purpose of consultative speech and hearing services.

Child's Name ______________________________________________

Parent/Guardian Signature ______________________________

Date________________________________________

Witness_______________________________________

# REFERRAL FORM

Child's Name________________________________________

DOB_______________ County of Residence_____________

Address_____________________________________________

____________________________________________________

Phone_______________ Parent/Guardian________________

Audiological Findings_______________________________

____________________________________________________

Treatment Plan______________________________________

____________________________________________________

Referred by ________________________________________

Phone______________________________

**Please fax along with release form and audiological/medical records to**

**304-696-2986 Attn: The L**